



Facility Name & ID Number Lakeland Healthcare Center# 0028654 Report Period Beginning: 07/01/00 Ending: 06/30/01

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>141</u>	Skilled (SNF)	<u>141</u>	<u>51,465</u>	1
2	<u>0</u>	Skilled Pediatric (SNF/PED)	<u>0</u>	<u>0</u>	2
3	<u>0</u>	Intermediate (ICF)	<u>0</u>	<u>0</u>	3
4	<u>0</u>	Intermediate/DD	<u>0</u>	<u>0</u>	4
5	<u>0</u>	Sheltered Care (SC)	<u>0</u>	<u>0</u>	5
6	<u>0</u>	ICF/DD 16 or Less	<u>0</u>	<u>0</u>	6
7	<u>141</u>	TOTALS	<u>141</u>	<u>51,465</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,074</u>	<u>335</u>	<u>5,045</u>	<u>8,454</u>	8
9	SNF/PED	<u>0</u>	<u>0</u>	<u>0</u>		9
10	ICF	<u>18,758</u>	<u>12,824</u>	<u>127</u>	<u>31,709</u>	10
11	ICF/DD	<u>0</u>	<u>0</u>	<u>0</u>		11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS	<u>0</u>	<u>0</u>	<u>0</u>		13
14	TOTALS	<u>21,832</u>	<u>13,159</u>	<u>5,172</u>	<u>40,163</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 78.04%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 6/8/1984

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 06/08/84 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 40 and days of care provided 5,008Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30 Fiscal Year: 6/30

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Lakeland Healthcare Center

# 0028654

Report Period Beginning: 07/01/00

Ending: 06/30/01

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	152,611	15,256	12,547	180,414		180,414	(2,535)	177,879			1
2	Food Purchase		163,274		163,274		163,274	(536)	162,738			2
3	Housekeeping	84,851	16,796		101,647		101,647		101,647			3
4	Laundry	41,250	18,398		59,648		59,648		59,648			4
5	Heat and Other Utilities			114,597	114,597		114,597		114,597			5
6	Maintenance	34,618	12,555	51,654	98,827		98,827		98,827			6
7	Other (specify):*			4,604	4,604		4,604		4,604			7
8	<b>TOTAL General Services</b>	313,330	226,279	183,402	723,011		723,011	(3,071)	719,940			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			3,500	3,500		3,500		3,500			9
10	Nursing and Medical Records	1,307,313	44,488	6,669	1,358,470		1,358,470		1,358,470			10
10a	Therapy		191	303,426	303,617		303,617		303,617			10a
11	Activities	51,932	5,491	2,777	60,200		60,200		60,200			11
12	Social Services	37,278	379	2,709	40,366		40,366		40,366			12
13	Nurse Aide Training					600	600		600			13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,396,523	50,549	319,081	1,766,153	600	1,766,753		1,766,753			16
	<b>C. General Administration</b>											
17	Administrative	57,200	(8)		57,192		57,192		57,192			17
18	Directors Fees											18
19	Professional Services			260,133	260,133		260,133	16,735	276,868			19
20	Dues, Fees, Subscriptions & Promotions			54,940	54,940		54,940	(26,901)	28,039			20
21	Clerical & General Office Expenses	118,543	25,657	92,426	236,626		236,626	(70,967)	165,659			21
22	Employee Benefits & Payroll Taxes			238,074	238,074		238,074	6,232	244,306			22
23	Inservice Training & Education			2,868	2,868	(600)	2,268		2,268			23
24	Travel and Seminar			6,582	6,582		6,582	1,387	7,969			24
25	Other Admin. Staff Transportation			4,222	4,222		4,222		4,222			25
26	Insurance-Prop.Liab.Malpractice			76,436	76,436		76,436	2,493	78,929			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	175,743	25,649	735,681	937,073	(600)	936,473	(71,021)	865,452			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,885,596	302,477	1,238,164	3,426,237		3,426,237	(74,092)	3,352,145			29

\* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			159,785	159,785		159,785	28,056	187,841			30
31	Amortization of Pre-Op. & Org.			33,928	33,928		33,928	(33,928)				31
32	Interest			704,233	704,233		704,233	(7,393)	696,840			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,193	2,193		2,193		2,193			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			900,139	900,139		900,139	(13,265)	886,874			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	3,378	126,607	20,217	150,202		150,202		150,202			39
40	Barber and Beauty Shops							(673)	(673)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			77,197	77,197		77,197		77,197			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	3,378	126,607	97,414	227,399		227,399	(673)	226,726			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,888,974	429,084	2,235,717	4,553,775		4,553,775	(88,030)	4,465,745			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

	1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY
1	Day Care	\$		\$
2	Other Care for Outpatients			
3	Governmental Sponsored Special Programs			
4	Non-Patient Meals	(549)	1	
5	Telephone, TV & Radio in Resident Rooms			
6	Rented Facility Space		34	
7	Sale of Supplies to Non-Patients		39	
8	Laundry for Non-Patients		4	
9	Non-Straightline Depreciation			
10	Interest and Other Investment Income	(7,393)	32	
11	Discounts, Allowances, Rebates & Refunds			
12	Non-Working Officer's or Owner's Salary			
13	Sales Tax		32	
14	Non-Care Related Interest			
15	Non-Care Related Owner's Transactions			
16	Personal Expenses (Including Transportation)		2	
17	Non-Care Related Fees			
18	Fines and Penalties		25	
19	Entertainment			
20	Contributions	100	21	
21	Owner or Key-Man Insurance			
22	Special Legal Fees & Legal Retainers			
23	Malpractice Insurance for Individuals			
24	Bad Debt	(6,000)	21	
25	Fund Raising, Advertising and Promotional	(26,901)	20	
26	Income Taxes and Illinois Personal Property Replacement Tax			
27	Nurse Aide Training for Non-Employees			
28	Yellow Page Advertising			
29	Other-Attach Schedule	21,584		
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (19,159)		\$

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense	(33,928)	31
34	Adjustments for Related Organization Costs (Schedule VII)	(34,943)	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (68,871)	36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (88,030)	37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38			\$		38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47			\$		47

Lakeland Healthcare Center

ID# 0028654

Report Period Beginning: 07/01/00

Ending: 06/30/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vendor Income	\$ (1,986)	1	1
2	Barber and Beauty Revenue	(673)	40	2
3	Extraordinary Income/(Expense)			3
4	(Gain)/Loss on Sale of Assets	0	30	4
5	Miscellaneous (Income)/Expense	(3,277)	21	5
6	Adjust Depreciation Expense to Schedule XI	28,056	30	6
7	Raw foods rebate	(536)	2	7
8	Adjust R/E taxes to actual	0	33	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	21,584		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakeland Healthcare Center# 0028654

Report Period Beginning:

07/01/00

Ending:

06/30/01

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(2,535)	0	0	0	0	0	0	0	0	0	0	(2,535)	1
2	Food Purchase	(536)	0	0	0	0	0	0	0	0	0	0	(536)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(3,071)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,071)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	16,735	0	0	0	0	0	0	0	0	0	16,735	19
20	Fees, Subscriptions & Promotions	(26,901)	0	0	0	0	0	0	0	0	0	0	(26,901)	20
21	Clerical & General Office Expenses	(9,177)	(61,790)	0	0	0	0	0	0	0	0	0	(70,967)	21
22	Employee Benefits & Payroll Taxes	0	6,232	0	0	0	0	0	0	0	0	0	6,232	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,387	0	0	0	0	0	0	0	0	0	1,387	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,493	0	0	0	0	0	0	0	0	0	2,493	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(36,078)</b>	<b>(34,943)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(71,021)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(39,149)</b>	<b>(34,943)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(74,092)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakeland Healthcare Center# 0028654

Report Period Beginning:

07/01/00

Ending:

06/30/01

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	28,056	0	0	0	0	0	0	0	0	0	0	28,056	30
31	Amortization of Pre-Op. & Org.	(33,928)	0	0	0	0	0	0	0	0	0	0	(33,928)	31
32	Interest	(7,393)	0	0	0	0	0	0	0	0	0	0	(7,393)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(13,265)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(13,265)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(673)	0	0	0	0	0	0	0	0	0	0	(673)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>(673)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(673)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(53,087)</b>	<b>(34,943)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(88,030)</b>	<b>45</b>



Facility Name & ID Number Lakeland Healthcare Center# 0028654

Report Period Beginning:

07/01/00

Ending:

06/30/01

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached Listing				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	19 Professional Services	\$	MidAmerica Care Foundation	100.00%	\$ 16,735	\$ 16,735 1
2	V	21 Clerical & Other Gen. Office	62,943	MidAmerica Care Foundation	100.00%	1,153	(61,790) 2
3	V	22 Empl. Bfts & P/R Taxes		MidAmerica Care Foundation	100.00%	6,232	6,232 3
4	V	24 Travel and Seminar		MidAmerica Care Foundation	100.00%	1,387	1,387 4
5	V	26 Insurance		MidAmerica Care Foundation	100.00%	2,493	2,493 5
6	V						6
7	V						7
8	V						8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 62,943			\$ 28,000	\$ * (34,943) 14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lakeland Healthcare Center # 0028654 Report Period Beginning: 07/01/00 Ending: 06/30/01

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lakeland Healthcare Center# 0028654

Report Period Beginning:

07/01/00Ending: 06/30/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

MidAmerica Care Foundation

Street Address

7611 State Line Road, Suite 301

City / State / Zip Code

Kansas City, Missouri 64114

Phone Number

( 816) 444-0900

Fax Number

( 816) 822-8799

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Patient Days	325,461	13	\$ 135,609	\$ 40,163	\$ 16,735	1
2	21	Clerical & Other Gen. Office	Patient Days	325,461	13	9,341	40,163	1,153	2
3	22	Empl. Bfts & P/R Taxes	Patient Days	325,461	13	50,500	40,163	6,232	3
4	24	Travel and Seminar	Patient Days	325,461	13	11,236	40,163	1,387	4
5	26	Insurance	Patient Days	325,461	13	20,200	40,163	2,493	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 226,886	\$	\$ 28,000	25

Facility Name & ID Number Lakeland Healthcare Center# 0028654

Report Period Beginning:

07/01/00

Ending:

06/30/01

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Effingham Class 4(D) Bonds		X	Mortgage	Varies	4/1/1983	\$ 4,750,000	\$ 4,986,293	12/01/14	13.00%	\$ 668,618	1
2	Effingham County Treasurer		X	Past Due R/E Taxes	Varies	4/1/1991	141,907	67,747	04/01/16	9.00%	6,097	2
3	Illinois Guarantee Savings Bank		X	Chevy Van	\$631.00	4/1/1991	30,301	5,896	05/08/02	9.00%	583	3
4	Capital Lease		X	Capital Lease				4,416			325	4
5												5
	Working Capital											
6	Interest Income		X								(7,393)	6
7	Bushman	X		Tutera - Working Capital	Varies		133,110	134,074			11,571	7
8	Southside	X		MAC - Working Capital	Varies		354,448	355,868			17,039	8
9	TOTAL Facility Related				\$631.00		\$ 5,409,766	\$ 5,554,294			\$ 696,840	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 5,409,766	\$ 5,554,294			\$ 696,840	15

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Lakeland Healthcare Center**# **0028654** Report Period Beginning: **07/01/00** Ending: **06/30/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> <b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																												
1. Real Estate Tax accrual used on 2000 report.		\$	1																									
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																									
3. Under or (over) accrual (line 2 minus line 1).		\$	3																									
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																									
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5																									
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$      For 19      Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																									
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																									
Real Estate Tax History:																												
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1996</td><td>8</td></tr> <tr><td>1997</td><td>9</td></tr> <tr><td>1998</td><td>10</td></tr> <tr><td>1999</td><td>11</td></tr> <tr><td>2000</td><td>12</td></tr> </table>	1996	8	1997	9	1998	10	1999	11	2000	12	<table border="1"> <tr> <td></td> <td><b>FOR OHF USE ONLY</b></td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2000 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>			<b>FOR OHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2000 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1996	8																											
1997	9																											
1998	10																											
1999	11																											
2000	12																											
	<b>FOR OHF USE ONLY</b>																											
13	FROM R. E. TAX STATEMENT FOR 2000 \$	13																										
14	PLUS APPEAL COST FROM LINE 5 \$	14																										
15	LESS REFUND FROM LINE 6 \$	15																										
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																										

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Lakeland Healthcare Center COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0028654

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>N/A</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		<b>TOTALS</b>	\$ <u></u>	\$ <u></u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services?        YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A.
Square Feet:
50,500

B. General Construction Type:

Exterior
Brick and block

Frame

Number of Stories
1

C.
Does the Operating Entity?
☒
(a) Own the Facility
☐
(b) Rent from a Related Organization.
☐
(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D.
Does the Operating Entity?
☒
(a) Own the Equipment
☐
(b) Rent equipment from a Related Organization.
☐
(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?
☒
YES
☐
NO

If so, please complete the following:

1. Total Amount Incurred:
1,017,829

2. Number of Years Over Which it is Being Amortized:
Various

3. Current Period Amortization:
33,928

4. Dates Incurred:
Various

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name &amp; ID Number Lakeland Healthcare Center

# 0028654

Report Period Beginning:

07/01/00

Ending:

06/30/01

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	141	85	71	\$ 2,952,194	\$ 98,406	30	\$ 98,406	\$	\$ 1,681,139
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	1985 Additions	85	86,600	3,052	29	2,986	(66)	58,829	9
10	1986 Additions	86	22,938	602	15	1,529	927	22,938	10
11	1987 Additions	87	575	38	15	38	0	542	11
12	1988 Additions	88	2,988	149	20	149	0	1,992	12
13	1989 Additions	89	2,026		10			2,026	13
14	1990 Additions	90	29,911	2,493	12	2,493	(0)	28,263	14
15	1991 Additions	91	4,640		7			4,640	15
16	1992 Additions	92	18,877		8	2,360	2,360	18,693	16
17	1993 Additions	93	27,894	37	7	3,985	3,948	27,894	17
18	1994 Additions	94	212,289	17,689	13	16,330	(1,359)	128,113	18
19	1995 Additions	95	32,534	2,530	15	2,169	(361)	15,434	19
20	1996 Additions	96	58,325	4,027	15	3,888	(139)	20,377	20
21	1997 Additions	97	54,531	3,497	15	3,496	(1)	13,235	21
22	Remodel Men's Restroom	98	1,993	100	20	100	(0)	307	22
23	Site Work	98	11,975	1,197	10	1,198	1	2,994	23
24	Carpet	98	914	183	5	183	(0)	503	24
25	Chiller Piping	98	2,300	153	15	153	0	486	25
26	A/C - North Dr.	98	1,050	105	10	105		306	26
27	Doors - Employee Entrance	99	880	59	15	59	(0)	142	27
28	Daycare Area (Furnishings)	2000	1,211	101	10	101		101	28
29	Daycare Area (Remodeling)	2000	2,027	118	10	118		118	29
30	Double Doors (Day care unit)	2001	1,498	33	15	33		33	30
31	Exit Device	2001	1,144	19	15	19		19	31
32	Install Doors (Day care unit)	2001	1,531	34	15	34		34	32
33	Carpet	2001	470	8	10	8		8	33
34									34
35									35
36									36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total



**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,533,315	\$ 134,630		\$ 139,939	\$ 5,309	\$ 2,029,166	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 421,091	\$ 18,453	\$ 41,200	\$ 22,747	10 - 15	\$ 323,869	71
72	Current Year Purchases	14,690	642	642		7 - 10	642	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 435,781	\$ 19,095	\$ 41,842	\$ 22,747		\$ 324,511	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		97 Ford Van	97	\$ 30,301	\$ 6,060	\$ 6,060		5	\$ 25,251	76
77										77
78										78
79										79
80	TOTALS			\$ 30,301	\$ 6,060	\$ 6,060			\$ 25,251	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,999,397	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 159,785	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 187,841	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 28,056	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,378,928	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	WIP	\$ 52,278	92
93			93
94			94
95		\$ 52,278	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 2,193 Description: See attached detail

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2002 \$ \_\_\_\_\_

13. \_\_\_\_\_/2003 \$ \_\_\_\_\_

14. \_\_\_\_\_/2004 \$ \_\_\_\_\_

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input checked="checked" type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	\$
2	Books and Supplies		133		600
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 133	\$ 467	\$	\$ 600
10	SUM OF line 9, col. 1 and 2 (e)	\$ 600			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	7
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	2
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>9</b>

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
					Units	Cost									
1	Licensed Occupational Therapist		hrs	\$		1,867	\$ 98,948	\$	1,867	\$ 98,948	1				
2	Licensed Speech and Language Development Therapist		hrs			700	14,692		700	14,692	2				
3	Licensed Recreational Therapist		hrs								3				
4	Licensed Physical Therapist		hrs			3,525	158,631		3,525	158,631	4				
5	Physician Care		visits								5				
6	Dental Care		visits								6				
7	Work Related Program		hrs								7				
8	Habilitation		hrs								8				
9	Pharmacy		# of prescripts								9				
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10				
11	Academic Education		hrs								11				
12	Exceptional Care Program										12				
13	Other (specify):										13				
14	TOTAL			\$		6,092	\$ 272,271	\$	6,092	\$ 272,271	14				

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 592,567	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	494,260		3
4	Supply Inventory (priced at )	10,624		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	795		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,098,246	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,480,671		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	571,004		16
17	Accumulated Depreciation (book methods)	(2,958,527)		17
18	Deferred Charges	1,017,829		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	1,235		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,112,212	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,210,458	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 198,378	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	8,359,909		29
30	Accrued Salaries Payable	125,624		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Other liab.'s and Patient Trust Dep	13,241		36
37	Due to affiliates			37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 8,697,152	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	60,889		39
40	Mortgage Payable	4,986,293		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 5,047,182	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 13,744,334	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (10,533,876)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,210,458	\$	48

\*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (10,201,961)	1
2	Restatements (describe):		2
3	Prior Year Adjustment	15,865	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (10,186,096)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(347,780)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (347,780)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (10,533,876)	24 *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,758,410	1
2	Discounts and Allowances for all Levels	(1,367,301)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,391,109	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	849,326	6
7	Oxygen	13,261	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 862,587	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,986	12
13	Barber and Beauty Care	673	13
14	Non-Patient Meals	549	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 3,208	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	7,393	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,393	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Extraordinary Income/Loss &amp; Misc.</b>	(58,302)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (58,302)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,205,995	30

2			
	Expenses	Amount	
<b>A. Operating Expenses</b>			
31	General Services	723,011	31
32	Health Care	1,766,153	32
33	General Administration	937,073	33
<b>B. Capital Expense</b>			
34	Ownership	900,139	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	150,202	35
36	Provider Participation Fee	77,197	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,553,775	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(347,780)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (347,780)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



Facility Name & ID Number **Lakeland Healthcare Center**# **0028654**Report Period Beginning: **07/01/00**Ending: **06/30/01****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	7,907	8,359	\$ 149,921	\$ 17.94	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	9,944	10,437	173,095	16.58	3
4	Licensed Practical Nurses	19,802	20,783	290,330	13.97	4
5	Nurse Aides & Orderlies	72,173	75,708	677,925	8.95	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0			8
9	Activity Director	5,738	5,947	51,932	8.73	9
10	Activity Assistants	0	0	0		10
11	Social Service Workers	3,668	3,795	37,278	9.82	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	20,907	21,749	152,611	7.02	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	3,260	3,455	34,618	10.02	17
18	Housekeepers	10,864	11,411	84,851	7.44	18
19	Laundry	6,592	7,088	41,250	5.82	19
20	Administrator	2,246	2,428	60,498	24.92	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	9,143	9,883	118,623	12.00	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	1,940	2,097	16,042	7.65	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	174,184	183,140	\$ 1,888,974 *	\$ 10.31	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	369	\$ 12,547	line 1, col 3	35
36	Medical Director	50	3,500	line 9, col 3	36
37	Medical Records Consultant	37	1,647	line 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	126	5,022	line 10, col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	50	2,487	line 11, col 3	44
45	Social Service Consultant	50	2,647	line 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	682	\$ 27,850		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	Ln 10, Col 1	50
51	Licensed Practical Nurses		0	Ln 10, Col 1	51
52	Nurse Aides		0	Ln 10, Col 1	52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number    **Lakeland Healthcare Center**

**XIX. SUPPORT SCHEDULES**

STATE OF ILLINOIS

#    **0028654**

Page 21

Report Period Beginning:    **07/01/00**    Ending:    **06/30/01**

<p><b>A. Administrative Salaries</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name</th> <th style="width: 10%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 10%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Boyer, Carol</td> <td>Administrator</td> <td></td> <td style="text-align: right;">\$ 57,200</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td style="text-align: right;">\$ 57,200</td> </tr> </tbody> </table> <p><b>B. 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Advertising PR & Other	26,901																																																																																																																																																																																																							
Dues & Subscriptions	7,792																																																																																																																																																																																																							
Less: Public Relations Expense	( )																																																																																																																																																																																																							
Non-allowable advertising	(26,901)																																																																																																																																																																																																							
Yellow page advertising	( )																																																																																																																																																																																																							
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 28,039																																																																																																																																																																																																							
Description	Amount																																																																																																																																																																																																							
Out-of-State Travel	\$																																																																																																																																																																																																							
In-State Travel	6,582																																																																																																																																																																																																							
Home Office Allocations	1,387																																																																																																																																																																																																							
Seminar Expense																																																																																																																																																																																																								
Entertainment Expense	( )																																																																																																																																																																																																							
(agree to Sch. V, line 24, col. 8)																																																																																																																																																																																																								
TOTAL	\$ 7,969																																																																																																																																																																																																							

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

[illegible]

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN, LPN, NA) represented by a union? N
- (2) Are there any dues to nursing home associations included on the cost report? Y  
If YES, give association name and amount. IHCA, 8053
- (3) Did the nursing home make political contributions or payments to a political organization? N If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? N If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Y  
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Y If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? N  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES N NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO N If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 77,197  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? N If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Y
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Y Indicate the amount. \$ 549
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? N  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? N If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0  
c. What percent of all travel expense relates to transportation of nurses and patients? 0%  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Y  
**g. Does the facility transport residents to and from day training? N**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Y  
Firm Name: BKD, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N If no, please explain. Not yet complete
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Y
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.